ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

RECEIVED
MAR 14 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Gateway Regional Medical Center
Street Address: 2100 Madison Avenue
City and Zip Code: Granite City, IL 62040
County: Madison Health Service Area 11 Health Planning Area: F-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Granite City Hospital Company, LLC d/b/a Gateway Regional Medical Center
Street Address: 2100 Madison Avenue
City and Zip Code: Granite City, 62040
Name of Registered Agent: CT Corporation
Registered Agent Street Address: 208 S. LaSalle Street
Registered Agent City and Zip Code: Chicago, IL 60604
Name of Chief Executive Officer: Ed Cunningham
CEO Street Address: 1573 Mallory Lane
CEO City and Zip Code: Brentwood, TN 37027
CEO Telephone Number: 615-465-7349

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Clare E. Connor
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 444 W. Lake Street, Suite 4000, Chicago, IL 60606
Telephone Number: 312-984-3365
E-mail Address: cconnor@mwe.com
Fax Number: 312-277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name: None
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Dan Kernebeck
Title: Chief Quality Officer
Company Name: Gateway Regional Medical Center
Address: 2100 Madison Avenue, Granite City, IL 62040
Telephone Number: 618-798-3623
E-mail Address: dan_kernebeck@quorumhealth.com
Fax Number: 618-798-3579

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Granite City Illinois Hospital Corporation
Address of Site Owner: 1573 Mallory Lane, Brentwood, TN 37027
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Granite City Illinois Hospital Company, LLC
Address: 1573 Mallory Lane, Brentwood, TN 37027
☐ Non-profit Corporation ☐ Partnership ☒ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Gateway Regional Medical Center
Street Address: 2100 Madison Avenue
City and Zip Code: Granite City, IL 62040
County: Madison Health Service Area 11 Health Planning Area: F-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Quorum Health Corporation
Street Address: 1573 Mallory Lane, Suite 100
City and Zip Code: Brentwood, TN 37027
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 S. LaSalle Street
Registered Agent City and Zip Code: Chicago, IL 60604
Name of Chief Executive Officer: Tom Miller
CEO Street Address: 1573 Mallory Lane, Suite 100
CEO City and Zip Code: Brentwood, TN 37027
CEO Telephone Number: 615-221-1400

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Clare E. Connor
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 444 West Lake Street, Suite 4000, Chicago, IL 60606
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E-mail Address: cconnor@mwe.com
Fax Number: 312-277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Flood Plain Requirements

[Refer to application instructions.] N/A - Discontinuation

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://** www.illinois.gov/sites/hfsrb).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.] N/A - Discontinuation

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Gateway Regional Medical Center ("Gateway" or "Hospital") temporarily discontinued its 14 bed rehabilitation unit in July of 2017 per Illinois Health Facilities and Services Review Board rules. It has determined it does not need to operate the service within the community. Its utilization has been low and since it temporarily discontinued the service in July of 2017 it has not become aware of any access issues, nor has it been advised of adverse impact. There is access to long term care services within the community through various other local providers.

There are no project costs associated with this discontinuation.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees	N	/	A
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ N/A.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): Within 30 days of issuance of exemption

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): **Not Applicable**

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Granite City Illinois Hospital Corporation in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Hal McCard
PRINTED NAME

Sr. V.P. and Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 28th day of February, 20 18

Signature of Notary

Seal

SIGNATURE

Martin Smith
PRINTED NAME

Director
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 28th day of February, 20 18

Signature of Notary

Seal

ROCHELLE D. PAYNE
TENNESSEE NOTARY PUBLIC
My Comm Exp September 22, 2019
COUNTY OF WILLIAMSON

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Quorum Health Corporation in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Hal McCard
PRINTED NAME

Sr. V.P. and Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of February, 2018

Signature of Notary

Seal

SIGNATURE

Martin Smith
PRINTED NAME

Director
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of February, 2018

Signature of Notary

Seal

ROCHELLE D. PAYNE TENNESSEE NOTARY PUBLIC My Comm Exp. September 22, 2019 COUNTY OF WILLIAMSON

ROCHELLE D. PAYNE TENNESSEE NOTARY PUBLIC My Comm Exp. September 22, 2019 COUNTY OF WILLIAMSON

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- ☐ Discontinuation of an Existing Health Care Facility
- ☒ Discontinuation of a category of service

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the

date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE			
	Year	**Year**	**Year**
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
18	Financial Viability	
19	Economic Feasibility	
20	Safety Net Impact Statement	
21	Charity Care Information	

Certificates of Good Standing - Applicants

Proof of Site Ownership

Not applicable. Discontinuation of Category of Service.

Licensee Certificate of Good Standing

File Number 0058590-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

GRANITE CITY ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 03, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* FEBRUARY *A.D.* 2018 .

Authentication #: 1805202784 verifiable until 02/21/2019

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

HF114789

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
1/2/2019		0005223

General Hospital

Effective: 01/03/2018

Granite City Illinois Hospital Company, LLC
dba Gateway Regional Medical Center
2100 Madison Avenue

Granite City, IL 62040

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #46240 5M 5/16

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 1/2/2019

Lic Number 0005223

Date Printed 12/22/2017

Granite City Illinois Hospital Company,
dba Gateway Regional Medical Center
2100 Madison Avenue
Granite City, IL 62040

FEE RECEIPT NO.

Attachment 10 - Discontinuation

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.

   Rehabilitation beds – 14 beds.

2. Identify all of the other clinical services that are to be discontinued.

   No other clinical services will be discontinued.

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

   The service has been temporarily discontinued since July of 2017 (per the Board's rules). It will permanently discontinue within thirty (30) days of issuance of an exemption.

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.

   There is no current use intended with respect to the space. However, one possibility would be to use it to offer more private medical surgical rooms (no increase in beds – just private rooms).

5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.

   The medical records will be maintained by the Hospital.

6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation. **N/A**

7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events. **N/A**

8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

   See Appendix A.

Attachment 10 – Discontinuation (Continued)

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

The utilization of the rehabilitation unit has been low. There are options for rehabilitation services within 12 miles of the Hospital. The Hospital temporarily discontinued the service to assess the impact on the community. It did not appear there was any negative impact.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

Given the low volume of the rehabilitation unit, we do not believe there will be any impact on the availability of the service to area residents. There is an excess of seven rehabilitation beds in the service area. While eliminating the fourteen beds will create a need for rehabilitation beds, the Hospital does not believe there will be an issue regarding access to this service as other area providers appear to have capacity. Further, the unit has been temporarily discontinued since July of 2017 without issue.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

See Appendix A.

Attachment 20 - Safety Net Impact Statement

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

   There is access to rehabilitation beds in the service area. The project will not have a material impact on essential safety net services in the community. In fact it may help other area providers of rehabilitation services by eliminating duplication and increasing their utilization slightly.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

   To the Hospital's knowledge this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

   To the Hospital's knowledge this discontinuation will have no impact on area safety net providers.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

   See attached table below. Note that the table in this attachment indicates the amount of Charity Care provided by Gateway.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

   See attached table below. Note that the table in this attachment indicates the amount of care provided to Medicaid patients by Gateway.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

   The utilization of the Unit has been declining, there are other providers of rehabilitation services within 12 miles and area residents will continue to have access to these services.

A table in the following format must be provided as part of Attachment 20.

Gateway Regional Medical Center

Safety Net Information per PA 96--031			
CHARITY CARE			
Charity (# of patients)	**Year 2014**	**Year 2015**	**Year 2016**
Inpatient	143	73	150
Outpatient	110	56	161
Total	**253**	**129**	**311**
Charity (cost in dollars)			
Inpatient	25,334.87	584,269.22	498,011.19
Outpatient	50,010.48	166,609.80	120,353.10
Total	**75,345.35**	750,879.19	**618,364.29**
MEDICAID			
Medicaid (# of patients)	**Year 2014**	**Year 2015**	**Year 2016**
Inpatient	2934	3354	3671
Outpatient	25,777	30,258	31,059
Total	**28,711**	**33,612**	**34,730**
Medicaid (gross revenue)			
Inpatient	133,063,370	149,808,907	181,986,983
Outpatient	124,580,929	155,069,943	164,225,975
Total			

Attachment 21 – Charity Care Information

Charity Care Information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

See table below. This table reflects charity care provided by Quorum Health.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

See table below. This table reflects charity care provided by the co-applicant Quorum Health (Illinois only). Apart from Gateway, other facilities under Quorum Health are neither involved nor relevant to this discontinuation. For charity care information for Gateway, please see the previous attachment.

4. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

N/A-Existing

Charity care means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third party payer (20 ILCS 3960/3). Charity care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 21.

Quorum Health Corporation*

CHARITY CARE			
	Year 2014	**Year 2015**	**Year 2016**
Net Patient Revenue	$101,025,789	$105,914,491	$112,464,499
Amount of Charity Care (charges)	$4,235,416	$8,447,850	$6,838,570
Cost of Charity Care	$75,345	$750,879	$618,364

*Illinois Hospitals Only. Quorum Health Corporation is a for profit entity and is not required to provide charity care. Nonetheless it does so.

APPENDIX A

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

Alton Memorial Hospital
One Memorial Drive
Alton, Illinois 62002

Signature Confirmation # 91 3499 9991 7030 3014 5619

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
- Whether your facility has, or will have, available capacity to accommodate a portion or all of our experienced caseload: our average daily census in CY2016 was *3.2.*

A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

Signature Confirmation # 91 3499 9991 7030 3014 5602

Anderson Hospital
6800 State Route 162
Maryville, Illinois 62062

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
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A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

Signature Confirmation # 91 3499 9991 7030 3014 5596

Memorial Hospital
4500 Memorial Drive
Belleville, Illinois 62226-5399

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
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A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

Memorial Hospital East
1404 Cross Street
Shiloh, Illinois 62269

Signature Confirmation # 91 3499 9991 7030 3014 5589

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

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Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

OSF Saint Anthony's Health Center
1 Saint Anthony's Way
Alton, Illinois 62002

Signature Confirmation # 91 3499 9991 7030 3014 5572

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

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Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

FILE COPY

GATEWAY REGIONAL MEDICAL CENTER

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

St. Elizabeth's Hospital
211 South 3rd Street
Belleville, Illinois 62220

Signature Confirmation # 91 3499 9991 7030 3014 5565

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
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A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

St. Joseph's Hospital
9515 Holy Cross Lane
Breese, Illinois 62230

Signature Confirmation # 91 3499 9991 7030 3014 5558

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

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A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

St. Joseph's Hospital
12866 Troxler Avenue
Highland, Illinois 62249

Signature Confirmation # 91 3499 9991 7030 3014 5541

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
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A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

GATEWAY REGIONAL MEDICAL CENTER

FILE COPY

February 19, 2018

VIA U.S. CERTIFIED MAIL- *return receipt requested*

Signature Confirmation # 91 3499 9991 7030 3014 5534

Touchette Regional Hospital
5900 Bond Avenue
Centreville, Illinois 62207

RE: Proposed Discontinuation of 14 Acute Rehabilitation Beds

Dear Director:

Gateway Regional Medical Center, in Granite City, Illinois, plans to file for a Certificate of Exemption (COE) from the Illinois Health Facilities and Services Review Board (IHFSRB) for discontinuation of its hospital-based rehabilitation services.

Throughout this letter, and consistent with the provisions of Section 1110.130 of Title of the Illinois Administrative Code, you are asked to provide an impact statement. More specifically, you have the opportunity to comment on the following, among any other concerns:

- The anticipated date of discontinuation of our service: *we plan to close these 14 rehabilitation beds after issuance of an exemption by the IHFSRB, which we believe will be in the first quarter of 2018.*
- Whether your facility has, or will have, available capacity to accommodate a portion or all of our experienced caseload: our average daily census in CY2016 was *3.2.*

A copy of any response to this request that is received within fifteen days of your receipt of this letter will be forwarded to the IHSRB.

Sincerely,

M. Edward Cunningham
Chief Executive Officer
Gateway Regional Medical Center

[illegible] will be entered in accordance with the request of the Petition.

Dated 81-29, 2018, at Belleville, Illinois.

St. Clair County Circuit Clerk
Kahalah Clay
By:/s/ S. Custer
Deputy Clerk

Dustin S. Hudson
Dhudson@
neubauerlaw.org
Neubauer, Johnston & Hudson
955 Lincoln Highway
Fairview Heights, IL 62208
Phone: (618)632-5588
Fax: (618)632-5789

L-P1344517
(Feb. 22, Mar. 1 & 8)

March 22, 2018. Bidders will be considered on their ability to complete the work, their past work history, capability of financing the work, and their availability. ACI X is an equal opportunity employer.

L-P1344508 (Feb. 22)

ANTS; UNKNOWN HEIRS AND LEGATEES OF DOWDY WILLIAMS; IVORY WILLIAMS; UNKNOWN HEIRS ANO LEGATEES OF CHRISTINE WILLIAMS;
Defendants.
ADDRESS: 2101 Baker Avenue EAST ST. LOUIS, IL 62207
NO. 17-CH-311

NOTICE TO HEIRS AND LEGATEES

NOTICE IS HEREBY GIVEN TO YOU: Unknown Heirs and Legatees of Dowdy Williams, deceased, and Christine Williams, deceased, that on August 18, 2017, an Order was entered by the Court naming John Baricevic, of Chatham & Baricevic, 107 West Main Street, Belleville, Illinois 62220, Telephone: 618-233-2200, as the Special Representative for the above defendants under 735 ILCS 5/2-1008(b) (Death of a Party). The cause of action is for the foreclosure of a certain mortgage upon the premises commonly known as 2181 Baker Avenue Street, East St. Louis, Illinois 62207.

JOHN BARICEVIC - 3121537
Chatham & Baricevic
Attorney at Law
107 West Main Street
Belleville, Illinois 62220
john@chathamlaw.org
618-233-2200

L-P1343725
(Feb. 8, 15 & 22)

66 Pets

Attention Cat People: Give a cat a good & loving home. Find the newest member of your family in the BND Classifieds

BND

PUBLIC NOTICE IN THE CIRCUIT COURT OF THE TWENTIETH JUDICIAL CIRCUIT ST. CLAIR COUNTY, ILLINOIS

IN RE
THE ESTATE OF
DARVIN HETZEL,
A/k/a Dean Hetzel,
Deceased

No. 18-P-18

NOTICE FOR PUBLICATION-CLAIMS

Notice is given of the death of Darvin "Dean" Hetzel, of Belleville, St. Clair County, Illinois. Letters of office were issued on January 25, 2018 to Michele Ortman, 25 Burma Road, Belleville IL 62220, whose attorney is Paul M Storment, III, 424 South High St., Belleville, IL 62220.

Claims against the Estate may be filed in the Office of the Clerk of the Court at St. Clair County Courthouse, 10 Public Square, Belleville, IL 62220, or with the representative, or both, within six months from the 22nd day of February, 2018, being the date of first publication of this Notice. Any claim not filed within that period is barred. Copies of a claim filed with the Clerk must be mailed or delivered to the representative and to the attorney within 18 days after it is filed.

Dated this 20th day of February, 2018.

Michele Ortman, Independent Administrator of the Estate of Darvin Hetzel, Deceased,

By:/s/
Paul M. Storment, III

PAUL M.
STORMENT, III
#6207811
424 South High Street
Belleville, IL 62220
618-236-7711
p.storm.id@gmail.com
ATTORNEY FOR
ESTATE

L-P1344456
(Feb. 22, Mar. 1 & 8)

PUBLIC NOTICE

Gateway Regional Medical Center in Granite City intends to close its 14 bed acute rehabilitation unit and 19 bed skilled nursing unit after approval to do so is issued by the Illinois Health Facilities and Services Review Board (HFSRB). The discontinuation will occur in the first quarter of 2018 or early in the second quarter of 2018. The hospital intends to submit the required certificate of exemption by the end of February or early March 2018 and a copy of it and information about this discontinuation of the acute rehabilitation unit and skilled nursing unit can be found on the HFSRB website at www2.illinois.gov/sites/hfsrb. You may also contact Beth Ann Gailey at 618-798-3167 at Gateway Regional Medical Center.

L-P1344374
(Feb. 20, 21 & 22)

PUBLIC NOTICE

State of Illinois
SS.
County of St. Clair

This is to certify that the undersigned transacting a business in the said County and State under the name of **USAVE Cleaners - Rhoden**, at the following post office address: 5209 N. Illinois St., Fairview Heights, IL 62208, and that the true and real names of the persons owning, conducting, or transacting such business are as follows:

Brandonn Rhoden
Belleville, IL

L-P1343723
(Feb. 8, 15 & 22)

McDermott
Will&Emery

Boston Brussels Chicago Dallas Düsseldorf Frankfurt Houston London Los Angeles Miami
Milan Munich New York Orange County Paris Saoul Silicon Valley Washington, D.C.

Strategic alliance with MWE China Law Offices (Shanghai)

Clare E. Connor
Attorney at Law
cconnor@mwe.com
+1 312 984 3365

March 13, 2018

VIA FED EX

Courtney Avery
Illinois Health Facilities and Services Review Board
525 West Jefferson, 2nd Floor
Springfield, Illinois 62761

Re: Gateway Regional Medical Center/Discontinuation of Inpatient Pediatric and Rehabilitation Services

Dear Courtney:

Enclosed are two exemption applications, as referenced above. Also enclosed are the applicable filing fees. Should you have any questions or comments do not hesitate to contact me.

As always, thank you.

Very truly yours,

Clare E. Connor

cc: Mike Constantino
Ed Cunningham
Dan Kenenbeck

DM_US 89570631-1.100513.0020